Withholding identification number 133524651 1

40515120

Part D - Form NYS-1 corrections/additions

Use Part D **only** for corrections/additions for the quarter being reported in Part B of **this** return. To correct original withholding information reported on Form(s) NYS-1, complete columns a, b, c, and d. To report additional withholding information not previously submitted on Form(s) NYS-1, complete **only** columns c and d. Lines 12 through 15 on the front of this return **must** reflect these corrections/additions.

a Original last payroll date reported on Form NYS-1, Line A (MMDD)	b Original total withheld reported on Form NYS-1, line 4	c Correct last payroll date (MMDD)	d Correct total withheld
▶			
▶			
▶			
▶			
▶			
▶			

Part E - Change of business information

22. Enter below the address at which you want to receive this form, if different from the preprinted address.

MECHANICAL HEATING SUPPLY INC

461 TIMPSON PL

BRONX NY 10455

Taxpayer's trade name

c/o: ☐ attn: ☐ *(if applicable, mark either box and enter name)*

Number and street or PO box

City | State | ZIP Code

If the above address is for your paid preparer, mark this box and the c/o box, and enter preparer's name on the second line above ..... ☐

23. If you **permanently ceased paying wages**, enter the date (MMDDYY) of the final payroll *(see* Note *below)*.....

24. Did you sell or transfer all or part of your business? ◀ Yes ◀ No

If *Yes*, indicate if sale or transfer was in Whole or Part

Note: Complete Form DTF-95, *Business Tax Account Update*, to report changes in federal identification number/withholding ID number, ownership, business name, business activity, telephone number, owner/officer/partner/responsible person information, or changes that affect any other tax administered by the NYS Tax Department. For questions regarding additional changes to your unemployment insurance account, call (518) 485-8589.

If you are using a paid preparer or a payroll service, the section below must be completed.

Paid preparer's use	Preparer's signature *REFERENCE COPY PREPARED BY PAYCHEX.*	Telephone number	Date *DO NOT FILE.*	Mark an X if self-employed ☐	Preparer's SSN or PTIN
	Preparer's firm name *(or yours, if self-employed)* PAYCHEX, INC.	Address 1175 JOHN STREET WEST HENRIETTA,NY 14586-9199			Preparer's EIN 161124166
Payroll service name PAYCHEX, INC.					Payroll service's EIN 161124166

Checklist for mailing:

- **File original return and keep a copy for your records**
- **Complete lines 9 and 19 to ensure proper credit of payment**
- **Enter your withholding ID number on your remittance**
- **Make remittance payable to *NYS Employment Taxes***
- **Enter your telephone number in boxes below your signature**

Need help or forms? Call 1 800 972-1233

Mail to:

NYS EMPLOYMENT TAXES
PO BOX 4119
BINGHAMTON NY 13902-4119

NYS-45 (1/05) Quarterly Combined Withholding, Wage Reporting And Unemployment Insurance Return-Attachment

60515117

0021-D027 NY 07090 TAXPAY®

Withholding identification number 133524651 1

Mark an X in the applicable box(es):

A. Original X or Amended return

Jan 1 - Mar 31	Apr 1 - Jun 30	July 1 - Sep 30	Oct 1 - Dec 31	Tax Year 07
X				
1	2	3	4	YY

B. Other wages only reported on this page . . .

C. Seasonal employer . . . . . .

Employer legal name:

MECHANICAL HEATING SUPPLY INC

Quarterly employee/payee wage reporting information

Annual wage and withholding totals

If this return is for the 4th quarter or the last return you will be filing for the calendar year, complete columns d and e.

a Social security number	b Last name, first name, middle initial	c UI total remuneration/gross wages paid this quarter	d Gross wages or distribution *(see instr.)*	e Total tax withheld
051-58-7481	MULLEN ROBERT M	15400.00		
052-62-1337	ROMEZ RENETTA	5387.50		
058-76-3525	MONTES KENNDY	3846.15		
067-64-7039	JIMENEZ ESTEBAN	13372.10		
071-50-6653	RIVERA MARIA	5833.38		
073-60-5801	PEREZ ELLIOTT	11200.00		
081-42-7552	SANTIAGO MICHAEL	3430.00		
083-78-5563	DOUGLAS SANDRA M	4000.00		
083-86-3726	RAMPERSAD MEYNI	12200.00		
088-60-4231	CEPEDA MARTHA	7200.00		
092-50-1910	RIVERA FRANCISCO	67307.66		
097-58-1730	OROPEZA ARTHUR	5785.00		
098-56-1244	SANTIAGO DAVID	3650.08		
098-92-0659	ORELLANA RAFAEL A	288.00		
112-56-0159	PACHECO EDWIN	6760.96		
127-90-6692	AMADOB JOSE	400.00		
Page No. 1 of 3	**Total this page only .....**	166060.83		
	If first page, enter grand totals of all pages	177015.47		

Contact information *(see instructions)*	Name	Daytime telephone number
	REFERENCE COPY PREPARED BY PAYCHEX	DO NOT FILE

For office use only

Postmark

Received date

Mail to: NYS EMPLOYMENT TAXES
PO BOX 4119
BINGHAMTON NY 13902-4119

NYS-45-ATT-MN (1/05) Quarterly Combined Withholding, Wage Reporting And Unemployment Insurance Return-Attachment

60515117

0021-D027 NY 07090 TAXPAY®

Withholding identification number 133524651 1

Mark an X in the applicable box(es):

A. Original X or Amended return

Jan 1 - Mar 31 X | Apr 1 - Jun 30 | July 1 - Sep 30 | Oct 1 - Dec 31 | Tax Year 07

1 2 3 4 YY

B. Other wages only reported on this page . . .

C. Seasonal employer . . . . . .

Employer legal name:

MECHANICAL HEATING SUPPLY INC

Quarterly employee/payee wage reporting information

Annual wage and withholding totals
If this return is for the 4th quarter or the last return you will be filing for the calendar year, complete columns d and e.

a Social security number	b Last name, first name, middle initial	c UI total remuneration/gross wages paid this quarter	d Gross wages or distribution *(see instr.)*	e Total tax withheld
556-19-6128	GONZALEZ EDWARD	10523.00		

Page No. 2 of 3

Total this page only 10523.00

If first page, enter grand totals of all pages .....

Contact information *(see instructions)*	Name	Daytime telephone number
	REFERENCE COPY PREPARED BY PAYCHEX	DO NOT FILE

For office use only

Postmark | Received date

Mail to: **NYS EMPLOYMENT TAXES**
PO BOX 4119
BINGHAMTON NY 13902-4119

NYS-45-ATT-MN (1/05) Quarterly Combined Withholding, Wage Reporting And Unemployment Insurance Return-Attachment

60515117

0021-D027 NY 07090 TAXPAY®

Withholding identification number 133524651 1

Mark an X in the applicable box(es):

A. Original X or Amended return

Jan 1 - Mar 31 X | Apr 1 - Jun 30 | July 1 - Sep 30 | Oct 1 - Dec 31 | Tax Year 07

1 2 3 4 YY

B. Other wages only reported on this page . . . X

C. Seasonal employer . . . . . .

Employer legal name:

MECHANICAL HEATING SUPPLY INC

Quarterly employee/payee wage reporting information

Annual wage and withholding totals

If this return is for the 4th quarter or the last return you will be filing for the calendar year, complete columns d and e.

a Social security number	b Last name, first name, middle initial	c UI total remuneration/gross wages paid this quarter	d Gross wages or distribution *(see instr.)*	e Total tax withheld
112-56-0159	PACHECO EDWIN	244.64		
556-19-6128	GONZALEZ EDWARD	187.00		

Page No. 3 of 3

Total this page only 431.64

If first page, enter grand totals of all pages .....

Contact information *(see instructions)*	Name	Daytime telephone number
	REFERENCE COPY PREPARED BY PAYCHEX	DO NOT FILE

For office use only

Postmark | Received date

Mail to: **NYS EMPLOYMENT TAXES**
PO BOX 4119
BINGHAMTON NY 13902-4119

PAYCHEX

135 Chestnut Ridge Road
Montvale, NJ 07645

(201) 930-0500
www.paychex.com

July 31, 2008

RE: Mechanical Heating Supply Inc
476 Timpson Pl
Bronx, NY 10455
Jose Amadob
SS# XXX-XX-6692

Dear Sir or Madam:

Paychex, Inc., a national payroll processing service, has the responsibility to file and deposit payroll taxes and returns for Mechanical Heating Supply. To fulfill these responsibilities, Paychex has been appointed their Reporting Agent and been given Power of Attorney, effective January 18, 1999.

We are writing in response to your inquiry regarding Jose Amadob, Social Security #XXX-XX-6692. Please be advised, Mr. Amadob was added to payroll on 1/22/2007 and is still an active employee. He does not appear on any reports because there haven't been any reported wages.

Should you have any questions, please feel free to contact, Mimi at 201-930-0500 Ext. 3311.

Sincerely,

Mimi Manso
Senior Payroll Specialist
Paychex, Inc.

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

EMPLOYER'S REPORT OF WORK-RELATED ACCIDENT/OCCUPATIONAL DISEASE

Send this notice directly to Chair, Workers' Compensation Board at address shown on reverse side within ten (10) days after accident occurs. Answer all questions fully. Copy should also be sent to your workers' compensation insurance carrier. This form replaces all previous versions of Form C-2.

Failure to timely file Form C-2, as required by Section 110 of the Workers' Compensation Law, may subject the employer to a penalty of up to $2,500.

Amended

ANSWER ALL QUESTIONS FULLY

TYPEWRITER PREPARATION IS STRONGLY RECOMMENDED-INCLUDE ZIP CODE ON ALL ADDRESSES-EMPLOYEE'S S.S. NO. MUST BE ENTERED BELOW

WCB CASE NO. (If Known)	CARRIER CASE NO.	CODE NO.	WC POLICY NUMBER	DATE OF ACCIDENT	EMPLOYEE'S S.S NO.
		W204002	Z 1161 083-9	1/23/07	127-90-6692

1. (a) EMPLOYER'S NAME	(b) EMPLOYER'S MAILING ADDRESS	(c) OSHA CASE/FILE NO.
MECHANICAL HTG SUPPLY	461 TIMPSON PL. BX NY 10454	

(d) LOCATION (If Different From Mail Address)	(e) NATURE OF BUSINESS (Principal Products, Services, etc.)	(f) NYC U.I. EMPLOYER REG. NO.

2. (a) INSURANCE CARRIER	(b) CARRIER'S ADDRESS
THE STATE INSURANCE FUND	199 CHURCH ST. NY, NY 10007

3. (a) INJURED PERSON (First, M.I., Last)	(b) ADDRESS (Includes No. & Street, City, State, Zip & Apt. No.)
JOSE AMADOR	300 E 151ST STREET BX NY 10451

ACCIDENT

4. (a) ADDRESS WHERE ACCIDENT OCCURRED	(b) COUNTY	(c) WAS ACCIDENT ON EMPLOYER'S PREMISES?
461 TIMPSON PLACE	BRONX	☑ Yes ☐ No

5. TIME OF ACCIDENT	6. DEPT. WHERE REGULARLY EMPLOYED	7. (a) DATE STOPPED WORK BECAUSE OF THIS INJURY/ILLNESS	(b) WAS INJURED PAID IN FULL FOR DAY?
AM 3 PM	WAREHOUSE	1/23/07	☑ Yes ☐ No

INJURED PERSON

8. SEX	9. AGE	10. OCCUPATION (Specific job title at which employed)
M		WAREHOUSE HELP

11. (a) AVERAGE EARNINGS PER WEEK?	(b) TOTAL EARNINGS PAID DURING 52 WEEKS PRIOR TO DATE OF ACCIDENT (Include bonuses, overtime, value of lodging, etc.)
400.00	

12. (a) PART OR FULL TIME WORKER?	(b) INJURED WORKER'S WORK WEEK (Indicate days of week usually worked).
FULL	MON-FRI

NATURE OF INJURY

13. NATURE OF INJURY AND PART(S) OF BODY AFFECTED	14. (a) DID YOU PROVIDE MEDICAL CARE?	(b) IF YES, WHEN?
LEFT ARM	☐ Yes ☐ No	

15. (a) NAME AND ADDRESS OF DOCTOR	(b) NAME AND ADDRESS OF HOSPITAL
	LINCOLN HOSPITAL

16. (a) HAS EMPLOYEE RETURNED TO WORK?	(b) IF YES, DATE	(c) AT WHAT WEEKLY WAGE?
☐ Yes ☑ No		400.00

NOTE: FORM C-11 MUST BE FILED EACH TIME THERE IS A CHANGE IN EMPLOYMENT STATUS

CAUSE OF ACCIDENT

17. WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific, identify tools, equipment or material the employee was using.)

PUTTING BOXES ON UPPER SHELVES

18. HOW DID THE ACCIDENT OR EXPOSURE OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened and how it happened. Please use separate sheet if necessary.)

FELL OF LADDER (LEANING TOO MUCH TO SIDE CAUSING LADDER TO TIP OVER.)

19. OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE, e.g., the machine employee struck against or which struck him/her, the vapor or poison inhaled or swallowed, the chemical that irritated his/her skin. In cases of strains, the thing(s) he was lifting, pulling, etc.

FELL TO GROUND

FATAL CASES

20. (a) DATE OF DEATH	(b) NAME/ADDRESS OF NEAREST RELATIVE	(c) RELATIONSHIP

DATE OF THIS REPORT 2/2/07

SIGNED BY [signature]

DATE YOU OR SUPERVISOR FIRST KNEW OF INJURY 1/23/07

OFFICIAL TITLE President

CHECK BOX IF PREVIOUSLY REPORTED ON FORM C-2.1.

TEL. NO. & EXT. 718-402-9765

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

GRP 515

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
EMPLOYER'S REPORT OF INJURED EMPLOYEE'S CHANGE IN EMPLOYMENT STATUS RESULTING FROM INJURY

This report is to be filed directly with the Chairman, Workers' Compensation Board at address shown on reverse side as soon as the employment status of an injured employee, as reported on Form C-2, or on a previous C-11, is changed. Change in employment status includes return to work, discontinuance of work, increase or decrease of regular hours of work and increase or reduction in wages. A copy also should be sent to your insurance carrier.

Amended

THE STATE INSURANCE FUND, 199 CHURCH STREET, NEW YORK, NY 10007-1173

ALL COMMUNICATIONS SHOULD REFER TO THESE NUMBERS				
1. W.C.B. Case Number	2. Carrier Case Number	3. Carrier Code	4. Date of Injury	5. Claimant's Soc. Sec. No.
00000000	62036785 - 326	W204002	~~01/30/2007~~ 1/23/07	127-90-6692

	NAME	Address to which notices should be sent (Give Number and Street, City, State and Zip Code)
6. Injured Person	AMADOE JOSE	360 EAST 151ST STREET BRONX NY 10451
7. Employer	MECHANICAL HEATING SUPPLY INC	461 TIMPSON PLACE BRONX, NY 10455
8. Carrier	STATE INSURANCE FUND	199 CHURCH STREET, NEW YORK, NY 10007-1173

9. Date of most recent Employer's Report filed: (Check "X" form and give date filed.)
[X] C-2 2/2/07 [ ] C-11

10. Date Disability Began: 1/23/07 Hour of Day: A.M. 3:00 P.M.

11. Nature of Injury: Fell off ladder putting boxes on upper shelves - hurt left arm

12. Date of FIRST return to work following injury:

13. (a) Change of employment status resulting from above injury:

Employment Status	Hours per Day	Days per Week	Earnings	Occupation
Prior to Injury	8	5	400.00/wk	Warehouse Helper
Changed to	—	—		

(b) Date of this change in employment status:

(c) Remarks:

14. Loss of time resulting from above injury since first return to work:

From (Mo., Day, Year)	To (Mo., Day, Year)	Reason
		Still out - has not returned to work.

15. Is injured still under care of a physician? Not Known If so, give name of physician:

16. Has injured died? NO If so, state date of death:

Name and address of nearest relative known: Not Known

Date of this report 3-16-07 Firm Name Mechanical Heating Supply

Telephone No. 718-4029765 Signed by: Martha Lopez

Bookkeeper

Official Title

(1444)31460167-3

NOTICE OF WORKERS COMPENSATION HEARING

State of New York
WORKERS' COMPENSATION BOARD

PLACE OF HEARING	Part	Date of Hearing	Time	District Office
Workers Compensation Board 215 W. 125th Street, 4th Floor New York, NY 10027	18	07/07/2008	1:30 PM	NYC (800) 877-1373
	WCB Case No.			
	00710945		Date of Accident	WCB Home Page
			01/30/2007	www.wcb.state.ny.us
			Carrier ID No.	Carrier Case No.
			W204002	62036785-326
			CLAIMANT	
			Jose A Zelaya	

State Insurance Fund
199 Church St
New York, NY 10007-1100

300 East 151st Street
Apt # 2-F
Bronx, NY 10451

EMPLOYER Mechanical Heating Supply, Inc
476 Timpson Pl.
Bronx, NY 10455-4908

COPIES TO Jose A Zelaya
Caruso, Spillane, Leighton

PURPOSE OF HEARING:

Question of period and extent of disability. Question of rate of compensation and/or average weekly wage. Question of authorization for treatment/tests.

EVIDENCE TO BE PRODUCED:

By Claimant: Claimant to be present or case closed. Produce up-to-date medical.

By Employer Or Carrier: Produce medical reports.

IMPORTANT INFORMATION FOR THE CLAIMANT:

In a compensable workers' compensation case, bills for related medical treatment are the responsibility of your own employer or its workers' compensation insurance carrier. If you have used a private health insurance policy (Blue Cross, Blue Shield, G.H.I., H.I.P., or other) for payment of any bills in your workers' compensation case, please advise the private health insurer immediately.

In order to be reimbursed for any payments or co-payments you may have made for treatment or services which are the responsibility of the workers' compensation insurance carrier, you must tell the judge at this hearing about this payment.

718-585-1682

Dated: 06/10/2008

EC-16 (6/99) 46
(1444)31460167-3

THE BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION AND ASSURES HEARING LOCATIONS ACCESSIBLE TO THE DISABLED. CONTACT THE NEAREST BOARD OFFICE IF YOU HAVE SPECIAL ACCESSIBILITY NEEDS.

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
PO Box 5205
Binghamton, NY 13902-5205

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

Mechanical Holding Corp
461 Timpson Pl
Bronx, NY 10455-4910

DATE OF MAILING	CLAIMANT'S S.S. NO.
9/13/2007	
WCB CASE NO.	DATE OF ACCIDENT
00727198	01/23/2007
CARRIER CASE NO.	CARRIER I.D. NO.
62036785-326	W204002

CLAIMANT'S NAME	EMPLOYER'S NAME	CARRIER'S NAME
Jose A Zelaya	Mechanical Holding Corp	State Insurance Fund

NOTICE OF CANCELLATION OF CASE NUMBER

The case identified above was a **duplicate file** and has been cancelled. All records pertaining to this case have been combined with WCB case number 00710945 Use only this number in all future communications regarding this case.

Please note your records accordingly.

By Stacey Garman Unit Team7

Telephone No. (800)877-1373